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AUTHOR Orvaschel, Helen
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ABSTRACT

Many approaches to the assessment of psychopathology in children have been governed by the conception of the prepubescent child as being unable or unwilling to recognize and report on his or her own behavior. Behavior of interest to the evaluator is perceived as being particularly difficult to obtain. This conception of the child's abilities is particularly evident in the use of behavior checklists, which are almost always designed to be completed by an information source other than the child. Checklists are inexpensive to use, but for diagnosis of depression, for example, they function only as preliminary screening devices and require follow-up by other diagnostic methods. A syndrome determination requires an assessment capable of differential diagnosis, which checklists are not yet designed to do. Structured and semi-structured psychiatric interviews are capable of making a syndrome determination, however. These techniques provide for a more systematic evaluation of signs and symptoms of disorder, thereby reducing the information variance in diagnosis and further improving diagnostic reliability. (MP)

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Assessing Depression in Prepubescent Children: Self-report and Psychiatric Interview

Helen Orvaschel, Ph.D.

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*Helen Orvaschel, Ph.D., Assistant Professor of Psychiatry, Director, Child Psychiatrist Epidemiology, University of Pittsburgh School of Medicine, Western Psychiatric Institute and Clinic, 3811 O'Hara Street, Pittsburgh, Pennsylvania 15213.

Introduction

While no one would deny that children experience sadness as an affect, the concept of a depressive disorder in pre-pubescent children and the nature of the expression of the disorder have been controversial issues in the field of child mental health. Briefly stated, three positions have been expounded regarding the expression of childhood depression. The first position states that a depressive disorder could not occur in pre-pubertal children. Statements such as "The familiar manifestations of adult, non-psychotic depression are virtually nonexistent in childhood" by Rie (1966) exemplify this position. The second position held that a depressive disorder in children, while rare, would be expressed as masked depression or in terms of depressive equivalents. A quote from Anthony (1967), in his review of psychiatric disorders of childhood stated that, "Psychoneurotic, depressive disorders involve internalized conflicts in relation to deeply ambivalent feelings and are not commonly seen in their fully developed adult form in children, although what have been referred to as depressive equivalents may take the place of depression". Investigators taking this position suggested that children who are rebellious, disobedient, hypochondrical, destructive, irritable, hyperactive, or have problems in school are expressing depressive equivalents (Burks & Harrison, 1962; Toolan, 1962; Hollon, 1970; Brandes, 1971). Unfortunately, these symptoms would account for approximately 80% of child referrals. The third position is of more recent vintage and states that depressed children do exist and that their symptoms are similar to those characterizing the adult depressive syndrome.

Difficulties with the concept and recognition of childhood depression have, in part, been a reflection of the theoretical orientation and the technological status of the field. Historically, children were generally viewed as having adjustment reactions and little attention was paid to the development of more useful diagnostic categories. An overemphasis was also placed on psychoanalytic views of the child as well as presumed cognitive requisities to affective states. While there may still be some who do not as yet accept the existence of a depressive disorder in children, many child health professionals have determined that this disorder is an identifiable syndrome of childhood. The focus of more recent research has been on establishing the expression and improving the assessment of this disorder in children.

Diagnostic Criteria

In adult psychiatry, the introduction of diagnostic criteria systems such as the Research Diagnostic Criteria (RDC) (Spitzer, et al., 1978), the Feighner criteria (Feighner, et al., 1972) and more recently the DSM III criteria (APA, 1980) have helped to improve diagnostic reliability by prespecifying the symptoms necessary for specific categories of disorder. In contrast, the specification of criteria for the diagnosis of childhood depression has often added to, rather than reduced the diagnostic confusion of this disorder. For example, criteria introduced by Weinberg, et al., (1973) suggested that a diagnosis of childhood depression should be based on the presence of both dysphoric mood and self-deprecatory ideation, and two or more of the following eight symptoms: aggressive behavior, sleep disturbance, somatic complaints, change in school performance, diminished socialization, change in attitude toward school, loss of usual energy, and unusual change in appetite and/or weight; all symptoms required a duration of one month.

This criteria system resulted in the somewhat arbitrary diagnosis of prepubertal depression and an inflated estimate of the prevalence of the disorder in childhood. The problem inherent in the Weinberg criteria as well as in the concept of masked depression is that of distinguishing between depression as a symptom of other psychiatric syndromes and depression as a separate clinical entity. A number of investigators have begun to apply to children the unmodified adult diagnostic criteria of major depressive disorder (Carlson and Cantwell, 1979; 1980; Puig-Antich, et al., 1978; Weiner et al., 1977). These investigators have met with success in identifying groups that respond to antidepressant medication, have positive family histories of affective disorders and show neuroendocrine findings (growth hormone hyporesponsivity/cortisol hypersecretion) similar to those of adult depressives (Cytryn et al., in press; Poznanski & Zrull, 1970; Puig-Antich et al., 1979). While the criteria considered most appropriate for use in the diagnosis of childhood depression have not yet been agreed upon, it would seem reasonable to begin with criteria similar to those used for the adult syndrome. Researchers must then determine the areas in which variation in symptomatology occur for this age group and identify those behaviors which may be unique to a child's developmental level or maturity.

The issue of masked depression is relevant here. Children are almost always referred for treatment because their behavior has become annoying to adults around them, such as teachers or parents. Not all children with disruptive behavior are depressed, but some proportion of these children may be depressed and the behavior which precipitated the referral may be an age appropriate expression of their primary disturbance. A differential diagnosis should require a determination of the presence of the full affective syndrome in

addition to the presumed masking symptoms. Children with depression often differ from children with conduct or oppositional disorder in the chronicity of their disruptive behavior. A depressed child is less likely to have a long history of conduct problems. The referral often occurs because the child suddenly begins to act up in school or at home or shows a deterioration in previous levels of school performance. A systematic assessment of the child may then reveal the presence of an accompanying or underlying depression, which when treated ameliorates the secondary disruptive behavior.

Another common symtom in young children is separation anxiety. Approximately three quarters of depressed children under 10 years of age present with this symptom (Puig-Antich, 1980). Determining whether the problem is, in fact, separation anxiety, school refusal, or depression can be difficult. However, the depressed child would not show a complete alleviation of depressed affect in the presence of the primary attachment figure, although he or she may report feeling somewhat better (less sad) in that context. The child with separation anxiety will return to normal mood and functioning in the presence of the primary attachment figure, so that depression can often be ruled out as a separate syndrome for these children.

There are several other areas in which symptom expression differ in children and adults. These areas need further exploration so that the criteria used for a diagnosis of childhood depression are most appropriate for this age group. Such information would also aid in identifying areas in which intervention might be most effective.

Assessment

While establishing appropriate diagnostic criteria is crucial to the assessment of childhood depression, the manner or technique of assessment is also important. Many approaches to the assessment of psychopathology in children have been governed by a conception of the prepubescent child as one who is unable or unwilling to recognize and report on his or her own behavior, particularly the behavior of interest to the evaluator. This conception is particularly evident in the use of behavior checklists which are almost always designed to be completed by an informant other than the child.

More recent efforts have focused on the development of symptom checklists which do use the child as the informant, such as the Childrens' Depression Inventory by Kovacs (1977), as well as on the development of structured or semi-structured psychiatric interviews for use with children.

The choice between using a symptom checklist or a structured interview depends, to a large extent on the questions the investigator wishes to answer. Checklists are, of course, less expensive to use, but for a diagnosis of depression they function only as preliminary screening devices and require follow-up by diagnostic interview, since symptom ratings may not correspond to the diagnosis of a depressive syndrome. For example, one study found that 60% of 102 children referred to a neuropsychiatric unit presented with symptoms of depression, withdrawal, and suicidal ideation, (Carlson & Cantwell, 1979). However, only 27% were considered to have an affective disorder. Symptoms of depression are common to many emotional, behavioral, & physical disorders and do not, in themselves, constitute a depressive syn-

drome. A syndrome determination requires an assessment capable of differential diagnosis, which checklists are not yet designed to do.

Structured and semi-structured psychiatric interviews are capable of this type of assessment.

Several such interviews are currently available and include the Diagnostic Interview for Children and Adolescents (DICA) by Herjanic et al. (1975), the Interview Schedule for Children (ISC) by Kovacs (1981), the Schedule for Affective Disorders and Schizophrenia for School-Age Children, known as the kiddie-SADS, by Puig-Antich et al. (1978), and the Diagnostic Interview Schedule for Children (DISC) being developed by NIMH and collaborators. These interviews provide for a more systematic evaluation of signs and symptoms of disorder, thereby reducing the information variance in diagnosis and further improving diagnostic reliability (Endicott & Spitzer, 1978). Such techniques for ascertaining diagnostic information are also needed to make the systematic evaluation of psychopathological behavior in children more compatible with the rigorous standards necessary for research.

The direct interview of the child is particularly important in the assessment of depression, since other informants are often unable to provide information for this diagnosis. However, there have been many in the child mental health field who have been reluctant to use such interviews with prepubertal children. Arguments against their use have stated that children could not understand the questions, that children could not recognize or

explain their behavior and that such direct questions would seriously upset children.

Those agruments are usually put forth by professionals who have not used such interview methods with children.

Summarizing the results of two studies I've been involved with using the Kiddie-SADS to directly assess depression and other forms of psychopathology in children, (Orvaschel et al., 1981; Orvaschel, et al., 1982) we found that:

1. Children were cooperative and capable of providing the information required of them. In fact, most of the children enjoyed the interview and were readily forthcoming with information.

2. Mothers were more reliable than children in providing information on objective or time-related material such as treatment history and duration of problems but children were no less accurate than mothers in reporting on their current and past behaviors.

3. Most importantly, children were essential in providing information about their own internal states such as mood swings, fears, and guilt feelings. However, the combined information from both mothers and children was necessary for an accurate diagnostic picture.

For the assessment of depression, in particular, the direct and systematic questioning of the child in conjunction with the information derived from a care-taking informant is the procedure recommended for obtaining the most accurate evaluation of the childs psychiatric status.

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